



Pediatric Special Health Care Needs: Feeding Tubes

I. All Provider Levels

1. Follow the General Patient Care guidelines in section A1.
2. Establish patient responsiveness.
 - A. If cervical spine trauma is suspected, manually stabilize the spine.
3. Open the airway using a head tilt chin lift if no spinal trauma is suspected, or modified jaw thrust if spinal trauma is suspected.
 - A. Consider placing an oropharyngeal or nasopharyngeal airway adjunct if the airway cannot be maintained with positioning.
 - B. Suction as necessary.
 - C. If the child has a tracheostomy tube, follow Tracheostomy protocol in section V1 to manage the tracheostomy tube.
4. Assess the patient's breathing including rate, auscultation, inspection, effort and adequacy of ventilation as indicated by chest rise.
 - A. Obtain a pulse oximeter reading.
5. If breathing is adequate, place the child in a position of comfort and administer 100% oxygen.
6. If no breathing is present then position the airway and start bag mask ventilations using 100% oxygen.
 - A. If the child has a tracheostomy tube, follow Tracheostomy protocols in section V1 to manage the tracheostomy tube.



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I. All Provider Levels (continued)

7. If airway cannot be maintained, begin ventilations with B-V-M and initiate advanced airway management using a combi-tube.



Note Well: Do not use a combi-tube on a patient younger than 16 years of age or less than 5-feet tall.



Note Well: The EMT-I and EMT-P should use ET intubation.

8. Check pulse.
- A. If no pulse is present, begin chest compressions and follow the appropriate protocol.
9. Assess circulation and perfusion.
10. Ask the caregivers for the child's baseline vital signs.
11. Assess the abdomen for signs of distention.
- A. If distention is present, follow step 16 below.
12. Obtain a complete medical history for the patient, including a history of the present illness and the past medical history.
13. Determine if the cause of the emergency is related to the feeding tube by examining the feeding tube and its site of placement.
- A. Determine the type of feeding tube that is in place.
14. Call for ALS support.
- A. Initiate care and do not delay transport waiting for an ALS unit.



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I. All Provider Levels (continued)

15. Treat problems associated with the tube as per the following tables



<u>Naso or oral feeding tube</u>	<u>Treatment</u>
Complete catheter dislodgement	Assess for dehydration. Ask if the child has missed any feedings.
Partially dislodged catheter	Assess respiratory status. Ask the caregiver to check the tube position. If the tube's position cannot be confirmed, remove the tube by gently pulling the tube out of the nose or mouth. (ALS Only)
Gastric distention	Check for correct tube position. Connect an appropriately sized syringe to the external opening of the feeding tube. Aspirate until resistance is met. (See step 15). If blood is seen in the aspirated contents, contact medical control and report findings.



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I. All Provider Levels (continued)



<u>Button or Gastrostomy Tube</u>	<u>Treatment</u>
Complete catheter dislodgement	Assess for dehydration. Ask if the child has missed any feedings. Place some gauze over the site with direct pressure to site. Rapidly transport to an appropriate hospital. Reinsertion of the tube is needed immediately. Bring the dislodged tube with the child to the hospital.
Insertion site is irritated or bleeding	Cover the site with a sterile dressing and control any bleeding with direct pressure.
Gastric contents are leaking around catheter	Cover the site with sterile gauze and assess the abdomen. Causes for leakage may include balloon deflation, coughing, constipation, bowel obstruction, and seizure. Treat any medical problem according to the appropriate protocol.
Gastric distention	Check for correct tube placement. Then connect the appropriate tubing and syringe to the external opening of the feeding tube. (If the equipment is not available on the ambulance, ask the caregivers for supplies). Aspirate until resistance is met. Distention may be a cause of bowel obstruction or air in the stomach.
Obstructed tube	Transport immediately to an appropriate facility. The tube needs to be cleared or replaced immediately. Do not force fluids through the tube. Clamp tube.
Feeding tube adaptor breaks	Clamp the tube and transport immediately to an appropriate facility. The tube needs to be replaced.



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I. All Provider Levels (continued)

16. If there are fluids infusing through the feeding tube, determine the nature of the fluids and the time that the fluids were started.
 - A. Prior to transport, stop all infusing fluids, flush the tube with water and clamp the tube.
17. If abdominal distention is noted, decompress the stomach as follows:
 - A. Ask the caregivers for an appropriate size syringe (or tubing adaptor if the tube has an anti-reflux valve).
 - B. Place, or confirm placement of, the oropharyngeal/nasopharyngeal tube.
 - C. Unclamp the distal end of the tube.
 - D. Connect the syringe and tubing adaptor (if indicated) to the external opening of the tube.
 - E. Gently and slowly aspirate air and gastric contents until resistance is met.
 - F. The tube then can be either re-clamped or left open.
 - i. If left open, place the distal end of the tube in a cup below the level of the stomach so the contents can drain.
18. If there are fluids infusing through the feeding tube and ALS transport is not available, ask the primary care providers to stop the infusion, flush the tube with water, and clamp before transport.



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II. Advanced Life Support Providers

1. Initiate cardiac monitoring.
 - A. Treat any arrhythmias with the appropriate protocol.
2. If signs and symptoms of shock exist, obtain IV/IO access as age-appropriate and infuse a fluid bolus of 20cc/kg of normal saline.



Note Well: *BLS Providers cannot start an IV on a patient less than eight years of age*



Note Well: *An ALS unit must be en route or on scene.*



Note Well: *If IV access cannot be readily established and the child is younger than 6 years of age then ALS Providers only may proceed with IO access. If the child is over 6 years of age, then contact Medical Control for IO access.*



- A. Infuse a fluid bolus of 20cc/kg of normal saline.
 - i. This bolus may be repeated up to two times.
 - B. If signs and symptoms of shock do not exist, infuse normal saline at a KVO rate.
 - C. If a history consistent with possible dehydration is noted, infuse one fluid bolus at 20cc/kg of normal saline.



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III. Transport Decision

1. If fluids are infusing through the feeding tube, stop the infusion, flush the tube with water, and clamp.
2. If the fluid infusion was stopped within 30 minutes of transport time, (either before or after EMS arrival), transport the child sitting up.
3. Bring any of the child's medical charts or medical forms that the caregiver may have, as well as any supplies that the parent may have for the feeding tube.



Note Well: Some caregivers carry a "go bag" for their children with extra supplies. Ask the parent if they have a "go bag" or similar bag for their child and bring it to the hospital.

4. Initiate transport to the nearest appropriate facility as soon as possible.
5. Perform focused history and detailed physical exam en route to the hospital.
6. Reassess at least every 3-5 minutes, more frequently as necessary and possible.



This protocol was developed and revised by Children's National Medical Center, Center for Prehospital Pediatrics, Division of Emergency Medicine and Trauma Services, Washington, D.C.



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